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ABSTRACT

Presented is a case study of efforts of two consultants to encourage deinstitutionalization and compliance with Title 19 and Title 20 regulations at a church supported facility for 258 mentally retarded residents. Noted is conflict between deinstitutionalization requirements and the administration philosophy of providing kindly custodial care without individualized evaluation or programming. Priority areas for change in the institution are identified as sharing of decision making, open budgeting, an open-door policy, reduction of numbers of residents, and usage of the community. Also noted is the development of Individual Program Plans (IPP's) for residents and provision of inservice training to staff members. Reported are evaluation results indicating that the institution did meet federal and state standards and improved administrator attitudes; but that development of IPP's is time consuming. (DB)

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DEINSTITUTIONALIZATION OF THE MENTALLY RETARDED

A CASE STUDY

A Paper Presented at
The Council for Exceptional Children
56th Annual Convention
Kansas City, Missouri

May 2, 1978

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DEINSTITUTIONALIZATION OF THE MENTALLY RETARDED:

A CASE STUDY

This paper is divided into three parts. The first is a general overview of our roles and what we attempted to do. The second and third sections are what Retish attempted to do with the administrative staff and Leone attempted to do with the direct care staff. The third part also contains an overall evaluation of the project. Our goals are to give the reader a feeling of the institution, why our organization was called in, what we accomplished, and an evaluation of our work.

Part One

An Overview

The material in this paper is based upon a year's work in a church-supported residential facility for the mentally retarded. The residents were referred to this facility through the churches in the surrounding eight-state geographical area. Before entry, each of the parents were promised that they would never have to worry about their child again. The parents were welcome to visit any time and to meet with any of the staff.

The facility is self-supporting with a little money coming in through the church. Most financial support comes from tuition and contributions by friends of the facility.

The general notion for programming and care was that this was God's work and therefore, be kind to our "guests."

Staff

There are approximately 120 direct care workers at the institution. They had been hired to provide care for the clients, often referred to at the institution as guests. Most of this direct-care staff had not received any formal training in working with handicapped clients. The staff adopted the institution's policy toward the residents: "Meet their physical needs, make life a little easier for them, don't place any expectations on them." Consequently, the physically disabled, mentally retarded, and aged residents of the institution were waited on hand and foot.

Residents

The 258 residents of the facility ranged in age from 8 to 93. Many of the older residents had spent their entire life at the institution. Their typical day consisted of:

1. Being served breakfast.
2. Spending time in the day room.
3. Attending occupational therapy - often tearing up rags, a few worked on looms or strung beads (much of the finish work on stuffed dolls, etc., was done by the staff).
4. Attending church services.
5. Eating lunch.
6. Spending more time in the day room.
7. Spending free time - often in the day room.
8. Eating dinner.
9. Attending Boy Scouts, Girl Scouts, or services.

Once a month dances were held. On Saturdays field trips were taken. Field trips consisted of loading 25 residents on a bus at a time, driving them around the country side for an hour and returning to the institution. When we first visited the institution, we asked about where the residents went on the field trips. The driver candidly told us that they really didn't go anywhere. "We just drive around the country side they really like that," he said.

As we move through this presentation please don't get the idea that the developmental and social needs of some of the residents weren't being met. There were a few cases in which residents had special relationships with staff members and were allowed to exercise greater self-responsibility. However, the vast majority of the residents had only their physical needs met. As was mentioned earlier, the institution was a religiously affiliated facility. A very spiritual, well meaning, let's-help-out-these-poor-unfortunates attitude was pervasive. In teaching or training our own children we know that at times we have to use various techniques, whether denial or privileges, or logical consequences, in order to bring about a desired change in behavior. At the institution the residents were "unfortunates." No expectations were made of them. No privileges were denied to the residents for inappropriate behavior and no behaviors were systematically reinforced. Consequently, no new behaviors were taught to the residents. No contingencies were set up to teach the residents the self-help skills that we routinely expect of other members of the population.

The Facility

The institution is situated in a very unpopulated region 20 miles from a city of 40,000. The grounds consist of 400 acres with 7 residential units, an administrative building, a 400-seat chapel, a laundry and kitchen, and a number of farm buildings. The institution is a self-contained little village. Most of the workers come from small towns in the vicinity as the institution is one of the major employers in the area.

This residential facility was cited by the State as not being in compliance with Title 19 regulations for provision of services to its residents. As a result of this citation, our group (Human Development Systems) was asked to assist the institution in meeting these regulations and also to qualify for Title 20 assistance.

We were contracted on Friday and on Saturday, seven members of Human Development Systems (HDS) flew to the institution with two express purposes.

1. Become acquainted with the facility, resources, staff, and residents.

2. Prepare to write IPP's that would meet Title 19 standards.

The corrective measures or steps taken to bring the institution into compliance were conducted in two parts. Part one consisted of work with administrators of the institution and part two consisted of work with the direct care staff.

Part Two

Administrative Consultation

One of the tasks was to organize the force to work with the administrators of the institution. Interviews were conducted related to the purpose and goals of the program. It was determined that the goals of the institution were the antithesis of those of Title 19 and the direction that most of special education was taking. Self-contained is a good way to describe the institution with no thought given to getting the residents off of the grounds. The facility had a place for very young children and a grave-yard. No individualized programming occurred and no evaluation of each resident occurred.

The initial task was to encourage the administrators to admit that there was room for improvement and that the goal we had was in the best interests of all concerned. Therefore, individualized meetings were set up which basically served as an in-service for all involved with the goal of giving directions to the administration of the program. Other tasks such as record keeping, updating budgets, review of competency of staff, intra- and inter-department communication, and liaison with other agencies were also worked on.

After the initial meeting in which we tried to agree on direction, specific areas were targeted as priorities; (1) sharing of decision making, (2) open budgeting, (3) open-door policy, (4) reduction of residents, and (5) usage of community.

Each of these areas were worked on in separate session with the end result being an attempt to get consensus to pursue agreed upon goals. Five-

day inservices were conducted where the administrative staff plus members of an agency dealt with the problems. Change occurred in all areas only when administrators recognized that without these changes the institution would have to close its doors. As long as the outside threat existed we could only make behavioral change.

Other administrative changes that were identified had to do with communication planning and staffing ratios. What we were suggesting would cost more and also cause some decisions to be made outside of their tightly knit group. Therefore, we pushed to get more of the staff to be classified as administrators and be included in the decision-making process. We also felt that this infusion of new blood would cause change to occur at a quicker rate.

We also conducted two meetings that included the advisory board of the church to the institution. These meetings centered around best use of limited funds, quality of service and future roles of the institution. Loyalty to employees versus quality of service was a constant topic. We had identified two or three long-time employees who were not helping but we could not get the board to allow replacement. This reluctance to change permeated the system and utlimately caused less change to occur than we would have liked to have seen.

One of the most successful inservices we conducted dealt with the use of M.B.O.'s (Management by Objectives). We quickly determined that there was little short-or long-term planning for the institution. We therefore developed a three-day workshop that taught the administrators to identify short- and long-term goals, how to measure them, and then how to reset the goals.

Generally we developed concrete procedures. In reviewing the use of medication, we assisted in development of a review process. When ordering supplies, formats were developed that could be easily handled by individual resident units and the business department. When suggesting these changes we met continued resistance from administrators who indicated that this was God's work and should not be altered.

A problem that also pervaded the institution was the guarantee that was given to the parents regarding their children. The parents were assured of perpetual care and we were now talking about independent living. These two ideas seemed to be in conflict and needed to be resolved. We invited parents, administrators and the board to a meeting to talk about new techniques, institutional change and the law. Once again, the only dent we could make occurred when the leverage of the law and its ramifications on the residents and the program at the institution were discussed.

Many more areas of programming were marked for change. The resistence shown by the institution was met by our insistance on obeying the letter of the law. As time wore on we each grew accustomed to each other and cooperation and change did occur. When the guidelines for Title 20 were changed and relaxed, the institution sought ways to revert to old operating procedures and get us out of the picture. We acquiesed but some of the following changes did occur.

1. Improved ratio of staff to residents.
2. The development of IPP's.
3. On-going evaluation of program and personnel.
4. Better communication between disciplines.
5. Greater use of the community.
6. The development of a philosophy of habilitation and rehabilitation.
7. The reduction in size of the resident population.

We also failed to get change in some areas.

1. Greater trust among employees.
2. Shared decision making at all levels.
3. The construction of new facilities.
4. The hiring of new administrators.
5. Commitment to deinstitutionalization.

The overall evaluation of our impact varied. In follow up we found change but not as much as we wanted. The law was the greatest motivator and once guidelines were relaxed the system would not move. On the other hand, many of the changes initiated are being maintained and are an accepted part of the system. If one accepts mainstreaming as a positive approach, then the institution has made progress. New residents are encouraged to be productive, a building has been purchased for a group home in a larger community, and a liaison with the regional special education system has been developed.

The residents now have written plans about their future that are shared by workers. Changes in these plans occur and we perceive the residents as having a better chance at independence and a life outside of the institution.

While this work was being done with administrators another team of consultants was working with the direct-care staff and nonadministrative professionals at the institution. Part three of this paper deals with this aspect of the consultation at the institution and also includes an evaluation of the overall project.

Part Three

Direct-Care Staff Consultations, and Corrective Measures: An Evaluation

The corrective measures taken to bring the institution into compliance were conducted in two phases. The first phase, meeting the requirement of Title 19 consisted of the writing of IPP's (Individual Program Plans) for roughly one-half of the residents at the institution, conducting of inservice activities for the direct care and professional staff involved with residents, and the providing of follow up support service after the inservice.

The second phase conducted to bring the institution into compliance with Title 20 regulations, consisted of completing IPP's on the remaining 129 residents with the direct input and assistance of the staff, conducting of inservice activities for the remaining direct care and professional staff and, providing support service to the staff in implementation of the changes that the new programming had brought about at the institution.

As mentioned earlier the state had given the institution a number of compliance extensions before a site visit was conducted. The institution had balked at coming into line with state and federal regulations but faced with the loss of revenues reluctantly decided to hire outside consultants to help them "get their house in order."

During Phase I we had four weeks between the time our services were contracted and the time of the final compliance deadline established by the state social service surveyors. The situation was analogous to that of a shot gun wedding. The institution felt it was being forced to make changes that it didn't feel it really needed to make.

In writing the Individual Program Plans for Phase I, two all-day site visits weremade by a team of five consultants from the field of special education and administration. The five consultants divided themselves up, and each assigned him/herself to a specific building and group of residents. Each consultant had to assess the needs of 20-30 residents.

After each of the assessment visits to the institution, the consultants reviewed and examined each resident's file. With the information gathered from the visits and the examination of the files, we began to write Individual Program Plans (IPP's) for each resident. The IPP's specified short-term (2-4 months) goals for the resident and a long-term goal (1 year) specifying projected residential placement. The short-term goals specified measurable and observable behavior that the residents would learn. These short-term goals were written in regard to self-help skills, communication skills, social and recreational skills, and perceptual motor skills. The long-term projected placement goals specified one of the following levels:

Level I - Maintenance

Level II - Supervised living on campus

Level III - Independent living on campus

Level IV - Supervised group living off campus

Level V - Discharge or independent community living

At the time we began our work at the institution the majority of residents were at Level I (maintenance) and some were at Level II (supervised living on campus). Was this a 'band aid' approach? How well could five

outsiders write appropriate short- and long-term goals for residents in such a short time period with only minimal contact with the residents?

In delivering our services to the institution we were quite aware that we had a limited amount of time in which to work and that the staff at the institution had little or no expertise (or support) in developing programs and specifying new appropriate behaviors that the residents could learn. As consultants we were delivering a product, the IPP's, but we were also teaching a process. When we returned to the institution with our completed IPP's we were quite aware that in some instances we had over or under estimated particular residents' abilities. We saw our IPP's as a vehicle in which to teach the process of programming to the staff at the institution. This process will be explained further in the paper when follow-up activities and Phase II are discussed.

After writing the IPP's the five consultants returned to the institution to conduct our inservice for the staff and to provide support service.

The Phase I inservice was conducted on a Saturday. Staff attendance was mandatory and the staff was paid for the extra time spent in training. The content and structure of the inservice training program was developed around the skills needed by the staff to implement the IPP's.

The objectives of the inservice were that each direct care staff member would learn to:

1. Task analyze the successive steps in training residents in self-help and other skills.

2. Chart the frequency and conditions in which certain behaviors occur.

3. Record resident progress toward specific short-term goals.

4. Utilize the basic principles of behavior management including the concepts of contingency management and reinforcement.

In pursuing these objectives a large group introduction and demonstration of task analysis was held. Consultants role-played staff members teaching and residents learning new skills. Table setting was used as a general model for a skill that could be task analyzed and broken down into successive steps. The staff was instructed in breaking down skills into sequential behaviors that could be observed, assessed, and recorded (see Appendix A).

Following the large group demonstrations the staff returned with the consultants to the resident living units for further demonstration, discussion and initial implementation of the IPP's. During this part of the workshop we got into the process aspect of our work mentioned earlier. We rewrote IPP's with the staff, demonstrated how to teach specific skills to residents and answered numerous questions about the changes that were coming to the institution.

During the afternoon session in the resident living units we frequently heard staff remarks like "Joan can probably make her own bed and wash her hair independently but we've never been allowed to let her do that before." The staff then developed IPP's with us and became involved in the basic process of developing short-term goals for the residents. When someone proposed a short-term goal for a particular

resident, the staff task analyzed the skill and generated the successive steps involved in the acquisition of that skill.

A very vivid incident comes to mind in discussing this aspect of the inservice. When I had initially visited the institution, I met Hilda, an obese, middle aged, Downs Syndrome resident. Hilda was ambulatory but she refused to use the stairs. She only used the elevator in coming to and going from her room on the second floor of the building. During fire drills, when the elevator wasn't to be used, Hilda stayed in the building. When staff tried to get Hilda to use the stairs she threw tantrums. After meeting with Hilda and examining her file I decided to write a short-term goal for her that specified that she would learn to use the stairs on a daily basis and that she would do so without throwing a tantrum.

When the staff was reviewing the IPP's with me and saw what I had proposed as a short-term goal for Hilda I think they were skeptical. I asked the group who would be willing to take the responsibility for Hilda's death if she perished in a fire because she wouldn't use the stairs to leave the building. Some of the staff thought I was being unfair. "Hilda's retarded," they said. "She'll throw a fit. Transfer her to another building on the ground floor."

I decided to demonstrate how I would teach Hilda to use the stairs. I had never witnessed one of her tantrums and wasn't looking forward to the prospect. Afternoon activities were beginning in a half hour in another buiding on the grounds and I decided to see if I could get Hilda to use the stairs to leave the building on her way to the activity.

Did she throw a tantrum? She outweighed me, had a great set of vocal chords and was very difficult to move. I succeeded in getting her to the top of the stairs. I explained again that she was going to have to start using the stairs on a regular basis. I told her "You can scream and holler all you want but I'm going to take you down the stairs with me if you don't go by yourself." Fifteen minutes later we made it down to the first floor. Almost the entire staff was in the stairwell with Hilda and me. It was very melodramatic. I had to pull Hilda step by step. Her bottom was undoubtedly sore as she only walked down three or four of the steps.

I had demonstrated to the staff that expectations could be made of residents in spite of their throwing tantrums; that the IPP's were implementable; and that in teaching someone a new skill one had to be patient, firm and consistent. A month later during the follow up and support activities I was pleased to discover that the staff had taught Hilda to use the stairs on a daily basis without throwing a tantrum.

The overall evaluation at the end of the Phase I inservice was positive. Direct-care staff indicated that they wanted more time and assistance in training the residents. Concern was also raised in regard to lack of time and staff to implement the changes.

The follow up and support aspect of Phase I consisted of monitoring the progress of the staff in implementing the IPP's, assisting staff and resident supervisors in managing and organizing the paper work that was being generated by the changes, and providing reinforcement for doing a good job. We tried to support the notion that the role of the direct-care staff was changing from being primarily custodial to being

instructional. Most of the direct-care staff felt the changes were challenging and they were amazed at how many things the residents could learn to do for themselves.

Phase II of the corrective measures consisted of completing IPP's on the remaining 129 residents at the institution, the conducting of an inservice for the remaining direct-care and professional staff, and the providing of follow up and support services to the staff. In examining the product versus process nature of deinstitutionalization at the institution, Phase II is distinct from Phase I.

In Phase II we weren't primarily involved in doing direct work, i.e., delivering a product, completed IPP's that would meet minimum state and federal requirements; but rather, we were involved in teaching and demonstrating the process through which on-going programming for the developmentally disabled is conducted.

In completing the IPP's on the remaining residents we called in three additional consultants, an occupational therapist, a physical therapist, and a psychologist to evaluate the residents thoroughly and to update their files. A physician and a clinical psychologist also examined and reviewed the medications for each resident.

We conducted staffings on each of the residents to develop the appropriate short- and long-term goals on the IPP's. The staffings included the resident living supervisor, a direct care staff member, the director of programming for the institution, and one of the members of the consulting firm. Prior to the staffings the Staffing Input

Report (S.I.R.) and staffing procedures were explained to the staff involved (see Appendix B).

Following the conducting of the staffings an inservice similar to the one conducted in Phase I was held on campus. Utilizing the feedback from the first inservice, during the Phase II inservice, much more time was spent in small group work with the direct care staff in the residential units. Task analysis, charting and recording behavior, and teaching basic behavioral principles were the chief components of the workshop. More time was spent directly teaching residents new skills with the assistance of the staff.

The follow up activities for Phase II involved the monitoring of progress of the staff and the providing of reinforcement to the staff for quickly adapting to the changes that we had helped bring about at the institution.

Evaluation

What impact did HDS have on the institution? The institution met minimum federal and state standards as set by Titles 19 and 20. In addition, evaluative information was gathered from an informal interview with a resident living unit supervisor and from a questionnaire administered to the staff 22 months after the completion of the project.

The questionnaire (Appendix C) was sent to the institution to be filled out by all staff members. The returns were analyzed from the following perspectives:

1. Groups by job description, i.e. administrative, direct care, and professional.

2. Length of employment at institution.

Mean scores were computed on each item and broken down by the above criteria. Each item was counted only when the respondee answered. If no answer was given or 0 was indicated the individual s response was not counted for that particular item.

When eyeballing the data it is obvious that there are differences between new and old staff members. The new staff members do not view the situation at the institution as changing or that there has been much improvement in the activities for the residents.

Specifically the administration has the impression that the changes that have occurred have had a positive effect on the residents and the institution as a whole. The direct care and professional staff are more divided as to the effects of the changes. The professional and direct-care staff's responses were in the average to neutral level concerning the effects of the changes on the institution.

The professional staff responses indicated that they can get good support and assistance from their supervisors. They also felt, however, that the IPP's have generated too much paper work. Generally, responses of the professional staff were neutral towards the changes.

The direct-care staff feels that their jobs have become more difficult as a result of the changes at the institution. On the other hand, there is agreement that the programming changes are in the best interests of the residents.

All three groups indicated that the development of IPP's is very time consuming. However, professional and direct-care staff feel more

strongly about the extra work of individualizing the programs for the residents. There is general agreement that the changes that occurred at the institution are in the best interests of the staff and the residents.

APPENDIX A

Name _____ Birth da_____ Admission date _____

Resident Living Unit _____ Social Security Number _____

Long Term (One Year) Goal (Circle one): Level I: Supervised living on-campus; Level II: Semi-independent living on-campus; Level III: Independent living on-campus; Level IV: Semi-independent living off-campus; Level V: Indepe dent living off-campus. Comment: _____

_____

Short Term Goals: 1) (to be implemented immediately) _____

_____

2) _____

3) _____

4) _____

5) _____

Comment: _____

Date Began	Service & Person Responsible	Methods for Reaching Short Term Goals: Goal no.	Method	Weekly Review: Comments	Date	Initial of Reviewer	Completion Date

Name _____ Residence _____

Short-term Goal: _____

Task Analysis (Successive Steps)	Assessment (Date; Level)	Plan of Action (Daily/Weekly)	Reinforcers/contingencies (This should be a list of things or activities that the residents like to do.)
1.			1.
2.			
3.			
4.			
5.			2.
6.			
7.			
8.			
9.			3.
10.			
11.			
12.			
13.			4.
14.			
15.			
16.			
17.			5.
18.			
19.			
20.			

Observations/Frequency of behavior is to be recorded on the back of this sheet if necessary. Record only behavior that is measurable and observable and that can be charted or graphed.

Comments:

APPENDIX B

Staffing Input Report (SIR)

Name of Guest _____ Staff _____

Date of Report _____

Problems and Needs

Priorities

Habilitation Objectives

-- Long Term Objective (1 year): _____

_____

-- Intermediate Objective (6 months): _____

_____

-- Short Term Objective (3 months): _____

_____

-- Short Term Objective (3 months): _____

_____

Program Activities to Accomplish Short Term Objectives

EFFICIENT STAFFING PROCEDURES

The key to effective and efficient staffing includes the following ingredients:

1. Each team member should prepare a written statement before the staffing on any given guest. The statement should be specific with the write-up being not more than one-half page long.

2. The staff statement should conform to the SIR document developed specifically for the staffing of guests. Please complete the form.

3. The completed SIR document should be turned in two days before the actual staffing schedule on any given guest to the staffing leader.

4. The staffing leader should have a staffing guest folder to hold all completed SIR documents.

5. Each staff member should have read the SIR documents submitted by other members of the team prior to the meeting. Clarification, if needed should be discussed at the actual staffing.

6. First 10 minutes of the staffing should be used to discuss the SIR reports in terms of clarification, agreement or disagreement.

7. The next 10 minutes of the staffing should deal with the selection of the long, intermediate and the 3 short term objectives. Priorities should be listed and the top 4 selected from the SIR documents.

8. The actual formulation of the programming to accomplish the objectives should be done outside of the staffing. At least two staff per guest should be assigned to develop a specific rehabilitation program. This should be done within three days of the staffing, put in writing and sent to the staffing leader.

9. One of the staff in "8" should be assigned to follow-up on the actual programming to see whether the short term objectives have been instituted. This should be done no later than 14 days following the staffing date.

10. The actual program phase of the service plan should be brought up again in a scheduled way to complete the staffing on each guest.

STAFFING RESPONSIBILITIES

Team Leader

1. Prepare staffing schedule with the names of specific guests in writing and distribute to each team member.

2. Guide the conduct of the meeting. Ground rules for the meeting should be clearly spelled out, including the specification of responsibilities of each team member.

3. Using the information recorded in the "rough" of the Staff Minutes form, summarize the staffing on each guest.

4. Collects all SIR documents from each team member and files them in the Staff Guest Folder.

5. Assigns staffing recorder.

6. Makes sure that staffing minutes are typed no later than four days following staffings.

7. Assigns two staff each to write up a service habilitation program for an assigned guest.

8. Assigns one of staff in "7" to follow-up on whether the RSP has been initiated.

Team Member

1. Writes out a statement on problems and needs on each guest coming up for staffing. Submit write-up to Team Leader two days prior to staffing.

2. Reads all SIR documents submitted by other team members prior to meeting.

3. Attends all meetings and participates.

4. May be assigned the job of recording the staff discussions on guests.

5. Will be assigned with another staff to write up a rehabilitation program on individual guests.

6. Will be assigned to follow-up the status of service rehabilitation program on individual guests.

Staffing Minutes

Name of Guest _____ Assigned Building Staff _____

Staffing Date _____ Staff Recorder _____

Staff Present Staff Absent

- Chairperson:

Discussion - Baseline Information (Specific Problems and Needs)

Habilitation Objectives

-- Long Term Objectives (Year from staffing): 1 2 3 4 5

-- Intermediate Objective (6 months): _____

_____

-- Short Term Objective (Within 3 months): _____

_____

-- Short Term Objective (Within 3 months): _____

_____

-- Short Term Objective (Within 3 months): _____

_____

Staff Assignments:

-- Write Program (Within 3 days following staffing)*: _____

_____

-- Program Follow-up (Within 14 days following staffing): _____

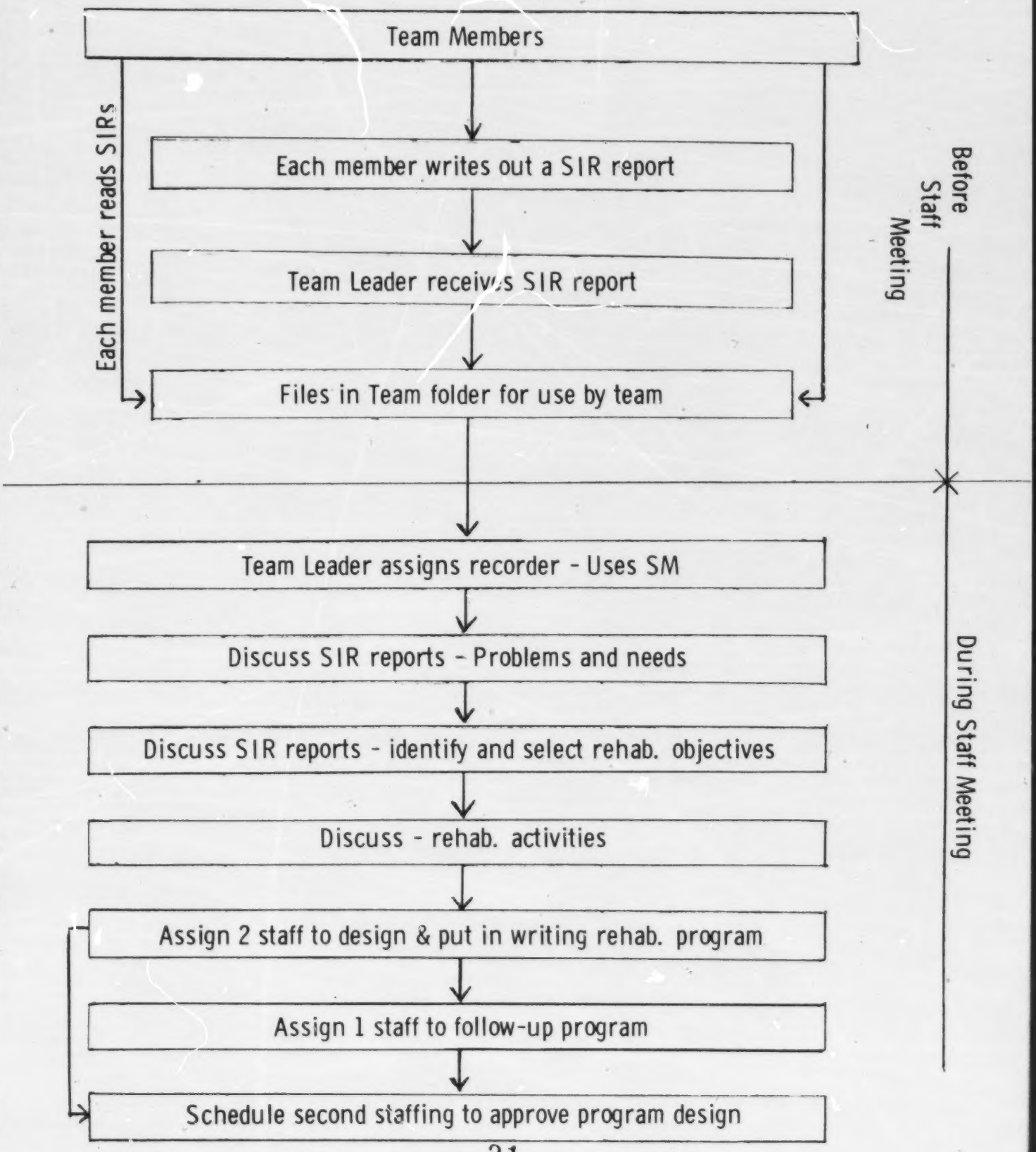
_____

* Assisted by HDS

SHL (6/76)

Team Staffing - Procedures & Sequence

Team


Team Members
Each member reads SIRs
Each member writes out a SIR report
Team Leader receives SIR report
Files in Team folder for use by team
Before Staff Meeting
Team Leader assigns recorder - Uses SM
Discuss SIR reports - Problems and needs
Discuss SIR reports - identify and select rehab. objectives
Discuss - rehab. activities
Assign 2 staff to design & put in writing rehab. program
Assign 1 staff to follow-up program
Schedule second staffing to approve program design
During Staff Meeting

APPENDIX C

QUESTIONNAIRE

During the spring and summer of 1976, Human Development Systems of Iowa City, Iowa, was involved in bringing about some changes at In an attempt to evaluate the effectiveness of our work at the we are asking the staff to fill out this questionnaire.

Please take a few minutes to fill out this form. Don't put your name on it as we want all responses to be confidential.

In responding to the statements on this form use the following five-point scale; 5 = Strongly Agree, 4 = Agree, 3 = Neutral, 2 = Disagree, 1 = Strongly Disagree, 0 = Doesn't Apply.

PLEASE CIRCLE ONE RESPONSE FOR EACH STATEMENT.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Doesn't Apply
1. Planning for the future is a good idea.	5	4	3	2	1	0
2. Developing Individual Program Plans for the guests is very time consuming.	5	4	3	2	1	0
3. The ratio of staff to guests has improved.	5	4	3	2	1	0
4. I have been able to get support and assistance from my supervisor.	5	4	3	2	1	0
5. Too many people have contact with the guests each day.	5	4	3	2	1	0
6. Some of the guests are being asked to do things that they aren't capable of doing.	5	4	3	2	1	0
7. I find that my job is more satisfying since the changes were made at .	5	4	3	2	1	0
8. Writing individual plans for guests has generated too much paper work.	5	4	3	2	1	0
9. Communication with other staff members has improved.	5	4	3	2	1	0
10. The guests seem more satisfied with themselves since the changes were made at the .	5	4	3	2	1	0

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Doesn't Apply
11. I like the way my job has changed since the summer of 1976.	5	4	3	2	1	0
12. I have some say in helping develop goals for the guests I work with.	5	4	3	2	1	0
13. The inservice training that H.D.S. held (June and July, 1976) taught me new skills that I am now using on the job.	5	4	3	2	1	0
14. My job is more difficult than it used to be.	5	4	3	2	1	0
15. The time spent in developing short- and long-term goals for the guests is worthwhile.	5	4	3	2	1	0
16. I like the programming changes that have occurred for the guests.	5	4	3	2	1	0
17. The overall atmosphere at has changed for the better.	5	4	3	2	1	0
PLEASE ADD ANY STATEMENTS THAT YOU THINK SHOULD HAVE BEEN INCLUDED.						
18.	5	4	3	2	1	0
19.	5	4	3	2	1	0
20.	5	4	3	2	1	0

Please indicate

1. How long have you worked at ?_____

2. What type of service you provide at : ____Direct care staff; ____ Professional staff; ____Administrative staff.

Use additional sheet for any comments or suggestions you might have.

Please return this form to Office by Friday, April 22.
Thank you for taking the time to complete this questionnaire.